Intermountain WorkMed

AT_____

REGISTRATION INFORMATION

(Required For NON-DOT Drug Screen Donors & Physical Exams Only)

Client ID (SSN): _____ Gender: ☐ Female ☐ Male

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Birth Date: _____

Company: _____ Department: _____

Work Phone: _____ Ext: _____ Supervisor: _____

Driver's License # _____ Class: A D State: _____ Expiration: _____ Class: _____

What is your preferred language? _____ Do you request interpretation services? ☐ Yes ☐ No

For Drug Screens
☐ Photo ID Verified Collector Initials _____

For Physicals
☐ ID Verified Clinic Staff Initials _____

CONSENT FOR SERVICES

☐ **NON-DOT Drug and Alcohol Testing at Intermountain WorkMed:** If I am here for a drug or alcohol test, I hereby authorize Intermountain WorkMed to release my specimen to an independent forensic toxicology laboratory designated by my employer/potential employer. I understand that the laboratory will perform tests for drugs and/or alcohol on samples of my urine, blood, or hair. I further authorize release of the test results to the designated representatives of my employer/potential employer. If requested, I agree to sign a separate Authorization to release the information. If applicable, I understand that Intermountain WorkMed follows manufacturer recommendations for the conduct and interpretation of Rapid Drug Screens and verifies each non-negative result with a certified laboratory before reporting the test as positive. I understand and agree that Intermountain WorkMed is not responsible for the work of any independent lab that may perform such tests. I agree that Intermountain WorkMed is not responsible for any actions my employer/potential employer may take or not take as the result of receiving the results of any test. I agree to notify Intermountain WorkMed of any information that I consider relevant to the test, including identification of currently or recently used prescription or nonprescription drugs, or other relevant medical information. I understand that I will not have a physician – patient relationship with Intermountain WorkMed as the result of the test and that Intermountain WorkMed will not release the results of the test to me.

☐ **Physical Examinations at Intermountain WorkMed:** I understand that my examination at Intermountain WorkMed is designed to help determine my ability to perform on the job and I agree that the results of the examination will be reported to my employer/potential employer. If the examination is done for the employer as part of an OSHA requirement, the employer will have access to this medical information. The Intermountain WorkMed physical is not a "complete physical" in that it does not check all things that normally would be checked in a physical examination performed by my private physician. I understand that I will not have a physician – patient relationship as the result of this examination, and I agree that the Intermountain WorkMed examination will not take the place of my regular check-up with my personal doctor. I understand that I should consult my personal doctor for any and all medical questions that arise either from the Intermountain WorkMed physical or otherwise, and that Intermountain WorkMed will not follow-up on any medical issues raised by its examination. I hereby release Intermountain WorkMed, its contractors, medical staff, and employees from either failing to discover or failing to advise me of any medical condition that may be present during or after the Intermountain WorkMed examination.

Responsibility: I understand that if I am here for an injury and workers compensation is denied for any reason, I am financially responsible for charges incurred in connection with all visits related to the injury, including costs, expenses, and reasonable attorney's fees if this matter is placed for collection.

I acknowledge that I have been offered or received a copy of the current Intermountain Healthcare Notice of Privacy Practices.

Signature: _____ **Date:** _____

NPP Given:_____

Intermountain WorkMed

Authorization for Intermountain WorkMed to Disclose Protected Health Information

(To be completed by injury patients, recipients of exams and non-DOT breath/urine test donors)

Authorization to release the health information of:

Name	Date of Birth

This authorization is to release health information to:

Company Name: Brigham Young University Phone: 801-422-4468

Address: BYU Campus City: Provo State: UT Zip: 84602

The purpose of this disclosure is (check all that apply)

☐ Employers request ☐ Employment related physical and/or work capacity determination ☐ NON-DOT Drug/Alcohol Test ☐ OSHA

Dates of service - (Today and/or Other Dates):

Release the following information (check all that apply)

☐ Physical examination & medical history, opinion of work capacity and applicable work restrictions	☐ NON-DOT Drug/Alcohol Specimen(s) and/or Reports	Other records as specified: ☐ DOT Exam Information ☐ OSHA Information	☐ Medical treatment report including physical examination, medical history and work capacity.

This Authorization will remain in effect until _____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed (whichever is sooner)

I understand that:

- Once Intermountain WorkMed discloses my health information by my request, it cannot guarantee that the Company mentioned above will not re-disclose my health information to a third party. The Company may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to Intermountain WorkMed to inspect and/or obtain a copy of my health information maintained at this facility (as provided in the Federal Privacy Rule 45 CFR §164.524).
- This Authorization will remain in effect until the Authorization expires as stated above, or until I provide a written notice of revocation to Intermountain WorkMed.
- I may refuse to sign this, but if I do, Intermountain WorkMed may not be able to provide the service, or Intermountain WorkMed may be required to report my refusal to my employer.
- I may change my mind in the future and ask Intermountain WorkMed not to send this information, if they have not already sent it; to do so I must provide a written request of revocation to Intermountain WorkMed. However, if I do, I may be required to pay for Intermountain WorkMed services, or, if this service was provided as a condition of my employment, my employer may take action regarding my employment as a result.

If I have questions about disclosure of my health information, I can contact Intermountain WorkMed at (801)442-3829

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Patient _____